EDITORIAL COMMENTS

Meningococcal Meningitis

Of interest is a recent report[1] of the endemic and epidemic aspects of meningococcal meningitis, which, presumably due to war conditions, has recently presented itself in epidemic proportions. Statistics for the United States indicate 1943 as the peak year, with the number of cases reported in 1943 and 1944 being the largest ever recorded. This experience has been worldwide. With the outbreak of hostilities in 1939 almost all the countries of the world have reported a greater incidence than in any previous epidemic.

Throughout the world there occurred a decline in the incidence of cerebrospinal meningitis following the epidemic at the close of World War I. The disease again gained epidemic proportions in 1929, first in North America and Eastern Europe, and a year or two later in Western Europe. There is no satisfactory explanation as to why the United States epidemic in 1936 had no counterpart in Europe, and why Australia and New Zealand have been relatively free of the infection between the two wars.

It is gratifying to note that the case fatality has been effectively reduced. For the United States as a whole "the case fatality of cerebrospinal meningitis, based on reported cases, has declined from 55% in 1930 to 39% in 1940 and 16% in 1943". In the first World War the United States Army had a 39% mortality. The effectiveness of the sulfonamides is shown by the fact that among cases occurring in the Fourth Service Command in the first 6 months of 1943, the mortality was reported to be only 3.3%.

MEDICAL ECONOMICS

The Wagner-Murray-Dingell Bill

[*The following extract has been taken from the condensed verbatim report in the "Journal of the American Medical Association" of the U.S. Senate Committee hearings on the Wagner-Murray-Dingell Bill. These hearings have been appearing regularly in the J. Am. M. Ass. and are worthy of the closest attention. We have been permitted to make the present extract from the J. Am. M. Ass., May 18, 1946. In it the case against compulsory health insurance is stated in admirably clear form. We have not the space for full reproduction of the very interesting cross examination of the witness, Dr. Goin, and have selected only some of the points brought out.—Ed. Canad. M. A. J.*]

STATEMENT OF DR. LOWELL S. GOIN OF LOS ANGELES

Dr. Goin: I am Lowell S. Goin of Los Angeles. I am a practicing physician, and I happen to be president of the California Physicians Service, which is a voluntary health care plan of California, and I am also president of the College of Radiology and the Radiological Society of North America. I feel a great sympathy for the objectives which are hoped to be attained by the enactment of this bill, and I admire the humanitarianism of those who work so hard for their attainment. There is not the slightest doubt that the sudden and unpredictable imposition of heavy costs for medical care is frequently catastrophic. The physicians of America are well aware of this and, individually and collectively, have devoted much time and energy to an attempt to solve the problem. They believe that a solution is becoming apparent and that, given reasonable time, will be reached. They believe that the solution will be a better one than that currently proposed and that more medical care, and much better medical care, will be available to the American people if voluntary plans are allowed to evolve than if compulsory health insurance becomes law. If it be argued that no voluntary plan completely meets the need, I reply that that is true, but that evolution is not a rapid process and that, in a field in which there is little or no experience, haste must be made slowly. That this is likewise true in government controlled compulsory health insurance plans is shown by German and British experience. Title II of S. 1606 (for example) contains seventeen sections, but the German insurance law had (before the war) grown to more than 3,300 sections—a certain indication of the complexity of the problem and of the impossibility of composing a neat and effective solution.

The American Medical Association, speaking (I am confident) for the overwhelming majority of American physicians, opposes this legislation on five grounds:

1. The existence of a need for it has been established more by emotional statements than by logic and documented facts.

2. Even if the need were soundly established there is no experience to indicate that compulsory health insurance would benefit the public health, although there is some reason to believe that it would lower the health standards.

3. The costs are totally unpredictable, and no one has even a fair idea of what such a program would cost.

4. Medical care is not the sole factor involved in good health, and there are many things that could properly be done to benefit the public health before we embark on a program such as is proposed.

5. Voluntary health plans are more in keeping with the American tradition and will result in far better care being given to our people.

I should like now to discuss each of these five points in turn:

1. The social planner maintains that the state of health of the American public is deplorable and that medical neglect is a commonplace oc-

1. GOVER, M. AND JACKSON, G: Public Health Reports, U.S. Public Health Service, **61**: 433, 1946.

currence. The reason, they say, is the interposition of a financial barrier between the sick man and the doctor and argue that to remove this barrier will solve our health problem. Last fall the President of the United States in a message to Congress pointed with horror to the shocking figures of Selective Service rejections as an indication of the dire need for the enactment of compulsory health insurance. Is it of no significance that our mortality and morbidity rates are among the lowest in the world? Is it an accident that the United States now leads the world in medical education? Is our constantly increasing expectancy of life a reflection of our deplorable state of health? Do you know that the American death rate for diphtheria is about one-half that of Great Britain or prewar Germany? Diphtheria, incidentally, is an excellent indicator, since it is one of the few diseases for which we have specific preventive and curative measures, and since, there being no secrets involved, the German and British physicians know as well how to treat it as do Americans.

So much has been made of the Selective Service rejection figures, the 5,000,000 4-F's, that they deserve a moment of special attention. Senator Pepper's interim report analyzes the 4,217,000 rejectees and breaks them down into groups. 444,800 were rejected as "manifestly disqualified". These included the armless and the legless, the totally blind, the totally deaf, the deaf mutes, and so on. What medical care could have made this group whole? How shall the amputated leg be restored, and who knows how to cure optic disease? The modern concept is that mental disease is largely a constitutional inborn inability to cope with reality. What has medical care to do with it? 582,100 were rejected for mental deficiency. That is to say, they simply lacked the intelligence to become soldiers or sailors or, indeed, useful citizens of any sort. They are the idiots, the imbeciles and the low grade morons. Even a very slight knowledge of eugenics will persuade any one that this group does not constitute a medical care problem. Together, these three groups reach a total of 1,727,600, or more than one-third of the rejectees. If they are now excluded, there remain 2,426,500, a little less than one-half the famous 5,000,000; 320,000 of these were rejected for musculoskeletal defects.

Senator Donnell: Of the total number, you mean?

Dr. Goin: That is the congenitally short leg, the club foot, the withered arm, the congenitally dislocated hip, the absence of a half vertebra and the consequent crooked back. How, I ask, would medical care have restored these unfortunates to usefulness? 280,000 were rejected for syphilis. Treatment for syphilis is offered freely everywhere. As a matter of fact our statute books are simply loaded about syphilis prevention. I doubt that there is a community in which a syphilitic person may not receive treatment from a department of public health. One wonders how compulsory health insurance would have eliminated this group; 220,000 were rejected for hernia, probably for hernias so severe that the Army was unwilling to attempt repair. I mean by that that likely these were bad hernias because I did think the army repaired some. Hernia is the result of a congenital defect in the inguinal or femoral canal, presumably due to a defect in the germ plasm. If such a defect exists, its bearer is likely to have a hernia, and medical care has nothing whatever to do with the occurrence of hernia; 160,000 were rejected for "eyes", by which I suppose is meant defective vision. Now it is true that some forms of blindness (ophthalmia neonatorum, for example) may be prevented by adequate medical care, and I think every state has a law requiring the instillation of silver into the eyes of the newborn, and it is my belief that ophthalmia neonatorum is practically an extinct disease, but I think it fair to assume that this group of 160,000 did not include the blind but those with visual errors too great to permit good or even fair vision. If one is born with an eyeball too long or too short or one that is not symmetrical, then one will have a refractive error and one will either wear glasses or not see very well, and medical care again has nothing at all to do with it. These groups total about 1,000,000, and the rejections which might be due to a lack of medical care are thus reduced to about 1,500,000, or about one-third of the shocking figure of 5,000,000. Although it is quite problematic whether any program of medical care would have altered substantially this figure, we many rest on it, confident that the figures fall a good bit short of establishing an urgent need for the enactment of compulsory health insurance.

2. Even if we had had thoroughly established the need for some better plan for medical care, it would be proper to inquire whether a proposed plan offered some reasonable probability of improving public health. Since compulsory health insurance has existed in various parts of the world for fairly long periods, it should be possible to examine the experience in those areas and, by analogy, establish the probable effect of our plans on our own health. I think it quite interesting to note that compulsory health insurance has been in effect in San Francisco for some years as regards the municipal employees. The insured are served by the same physicians and in the same hospitals as are noninsured persons. In spite of the fact that no financial barrier exists between an insured person and a physician, the incidence of ruptured appendix is higher among the insured than among the uninsured. In this instance, at least, the removal of the financial barrier, so abhorred of the social planner, did not seem

to benefit the insured public. The morbidity and mortality rates are higher in nearly all insurance countries than in our own. May I quote to you from Dr. Nathan Sinai's book "The War of Health Insurance"? Remember that he is a most able and ardent advocate of compulsory Health Insurance. He says that, "Contrary to all predictions, the most startling thing about the vital statistics of insurance countries is the steady and fairly rapid rate of increase in the number of days the average person is sick annually and the continuously increasing duration of such sickness. Various studies in the United States (he says) seem to show that the average recorded sickness per individual is from seven to nine days per year. It is nearly twice that amount among the insured population of Great Britain and Germany and has practically doubled in both countries since the installation of insurance."

Senator Donnell: Might I ask a question? What is the approximate date of Dr. Sinai's book, if you know?

Dr. Goin: I would say roughly 1943 or 1944, maybe it is 1942. This seems to me a rather sound argument against compulsory health insurance, although Dr. Sinai probably did not intend it thus. To clinch the matter, he adds "It seems to be a safe conclusion that insurance has certainly not reduced the amount of sickness". This puzzles me a little, since I have naïvely assumed that the intent was to reduce the amount of sickness and to improve health. I believe that the evidence in hand warrants the flat statement that compulsory health insurance will not benefit the public health.

3. When compulsory health insurance was proposed in California a year ago last January, no one appeared with any sound idea as to its cost. The guesses varied between $20 per person per year and $80 per person per year. Most thought that $40 was a fair figure. I think it significant that costs are nowhere discussed in the present bill, the Surgeon General of the Public Health Service being given a blank cheque. At $40 per person per year the program would cost 4,000 million dollars, and no one really knows whether this amount would suffice. Experience elsewhere indicates that there is needed at least one employee (not including those actually delivering medical service) for each hundred insured persons (Crownhard, J. G.: Sickness Insurance in Europe, 1938, p. 25). On this basis we would need to increase the government payroll by about 1.5 million employees. And yet, to pay this vast army, to pay the doctors, to pay for hospitalization and for the other benefits offered, no sums are named, no appropriations are made and no limits are set. This is a rich country, but no wealth is unlimited.

4. A sort of current custom is to use the terms "medical care" and "health" as if they were interchangeable—as though one were a synonym of the other. As a matter of fact, medical care is only a small part of the health problem —not even the most important part. Health consists largely in not being sick; medical care consists largely in an attempt to cure or alleviate disease. Nearly all—perhaps all—of the health legislation which has been proposed from time to time has been written by social planners, seldom, if ever, in consultation with physicians. Consequently nearly all of it contains much wishful thinking and not too much reality. Too much confidence is placed in preventive medicine, too much earnest belief that periodic health examinations will prevent disease, and all the legislation evidences a complete failure to understand that preventive medicine simply has not yet attained the goals wished for. To cite a few of the problems: How shall heart disease (except that due to rheumatic fever) be prevented? What sort of health examination will be efficient in its control? How shall we prevent, or even recognize, early brain tumours? Shall every one with a headache have encephalographic or ventriculographic studies? Shall we do gastrointestinal x-ray studies on every one with indigestion and, if so, where shall we obtain the skilled personnel? How are bone tumours prevented, and what periodic examination makes one aware of the pneumonia of next week? Medical care is, and will for a long time continue to be, the care of the sick, and this I repeat is only a fraction of the health problem. Some other fractions to which the government might well turn its attention are sanitation, hygiene, health education, adequate diet, good housing, adequate clothing, working conditions and "patent medicine" control. And there are many others. If government is sincerely interested in the health of the citizen, why should it not suppress "patent medicine" advertising? Why should it not regulate the cults and require that all who wish to practice the healing arts pass the same tests? Why should it not control radio publicity of nostrums, vitamins and the like? This current legislation is attacking only a small segment of the health problem, and even if it were to accomplish all that its proponents claim it still would not solve our health problems.

5. Voluntary health plans will, if given the opportunity, do the job, and do it better than government controlled plans can do. These plans, which already include a very large number of persons, are in accord with our traditional emphasis on personal responsibility, prudence, foresight and thrift. They have an American dignity which is lacking in the regimentation of compulsory health insurance. They can be and are more economically administered, they can and do give better medical care, and they will be and are supported by thousands of physicians who are bitterly and unalterably opposed to government controlled medicine. In California

we have made a good start. Our California Physicians Service offers medical care at modest costs. A quarter of a million of our people have availed themselves of it, and appear to be quite satisfied with it. The Farm Security Administration had a medical care program for the rural indigent. California Physicians Service took it over and gave better medical care for less money and to the satisfaction of those giving and receiving the care. California Physicians Service has just signed a contract with the State Grange providing medical care for nearly 100,000 farm people. These activities, which are duplicated in most of our states, are indications of how voluntary plans can meet the challenge—how they are meeting it, and how they will continue to do so with a steady and healthy growth if they are not crushed by the monster of bureaucratic control.

Senator Murray: Doctor, is it not true that most of the objections that are made to the compulsory system with reference to the relationship between physician and patient apply equally to the voluntary systems? Dr. Goin: Senator, I am really familiar only with the California voluntary system and in that instance I will answer "No, it is not true".

Senator Murray: Will you explain the California system again briefly? Dr. Goin: That is a voluntary health care plan in which people are enrolled as beneficiary members and are served by doctors who are professional members. The doctors are paid on what is called a unit basis; that is to say that the funds received in a given month are pooled and, after the necessary administrative expense and a reserve for unforeseen contingencies, such as an unexpected epidemic next month, are set aside, the remaining money is divided equally among the doctors on the basis of what service they have rendered. The minimum amount of medical service is presumed to be a visit to the doctor in his office, one office call. That is known as one unit. The fee schedule is then in multiples of that unit. There is no one that intervenes at all between the doctor and his patient. There are practically no regulations, none that I know of that concern the practice of medicine.

Senator Murray: Does your system give full coverage to the people that belong to it? Dr. Goin: Not quite, Senator.

Senator Murray: What do they cover? Dr. Goin: We have three types of contract that we offer. We offer the so-called catastrophic coverage, in which the insured is covered for hospitalization and surgery, including fractures and dislocations.

Senator Murray: That is only in cases of a catastrophe? Dr. Goin: It is a case requiring any sort of surgery plus fractures and dislocations which are considered to be surgery; they are specifically included. Then we have the same contract with the so-called medical rider, in which the patient receives medical care if he is hospitalized, and then we offer a third contract known as the "two visit deductible" in which the patient, the subscriber, is fully covered except that he must pay for the first two visits to the doctor. However, if the first two visits lead to hospitalization and surgery he is not obliged to pay for them. The purpose of the two visit deductible is to prevent the insured from imposing on the professional member.

Senator Murray: All three of the systems would not cover all the service that is proposed under the pending bill. Dr. Goin: All except the first two visits to the doctor, Senator.

Senator Murray: You do not provide for maternity care, do you? Dr. Goin: Yes, sir; after ten months. The subscriber must be a subscriber for ten months before she is eligible, but thereafter she is completely eligible.

Senator Murray: Do you provide dental care? Dr. Goin: No, sir.

Senator Murray: And no nursing care? Dr. Goin: The ordinary floor nursing in the hospital, no home nursing.

Senator Murray: And no eye care? Dr. Goin: What do you mean by that?

Senator Murray: Medical treatment of the eyes. Dr. Goin: We do not prescribe glasses, but any eye disease is just as amenable to treatment as any other disease.

Senator Murray: You take the position that the compulsory system would result in a deterioration of the medical service, of the medical profession in the country? Dr. Goin: I am persuaded of it.

Senator Murray: Is it not true that at one time the American medical profession considered favourably compulsory— Dr. Goin: That is true. I think we are all entitled to one mistake.

Senator Murray: That was a serious mistake made by very excellent men. Dr. Goin: That is right; but since that time we have developed a good deal of experience.

Senator Murray: But for a long time you were also opposed to a voluntary system. Dr. Goin: I could not say that is true. I think the American Medical Association did not regard voluntary care plans with much favour for some time, largely because there had been no experience developed, and no one knew how to do these things or whether they could be done. I think the doctors are rather complete realists. We face conditions as they are. If we have an incurable patient, for example, we do not hope to cure the patient, we hope to make him as comfortable as possible until death intervenes. They thus learn to be realistic. To want to do something and to do it are not synonymous terms, and I think for a long time we doubted whether there was enough experience in the world to justify any type of health insurance. I think slowly it is developing that there is an increasing amount of experience which does justify it, and therefore we have reversed our attitude and we now support these matters.

Senator Murray: Without some system of insurance, or some means of making modern medical care available to a large section of the people of this country, they would go without adequate care. Dr. Goin: No, I could not agree to that, Sir.

Senator Murray: You do not accept that at all? Dr. Goin: No, I do not.

Senator Murray: You think that the American people can get all the medical care they need? Dr. Goin: I heard Senator Pepper this morning describe the lack of medical care in his home state. Of course, I have no way to know what occurs in Senator Pepper's home state. But I can say this, that I have been in the practice of medicine for thirty-four years and that during that time I have never refused any person any medical care that I thought I was competent to give, nor do I know any of my fellows that have done so. Now perhaps there are people who have done otherwise.

Senator Murray: You think that the present system, then, of having the medical profession wherever they find patients coming to them that are unable to pay, that they should accept those patients and care for them? Dr. Goin: I certainly do. I think it is not only their duty, I think it is their privilege to do so.

Senator Murray: And you think that that would be the result in this country, if we did not have any compulsory system? Dr. Goin: No, sir. I do not wish to be misunderstood. I do not argue for the maintenance of the *status quo*. I think we must find some better way to distribute medical care. I am not yet sure what that better way is. My preference for the moment is for voluntary health care plans, but I think it is also true that one need not be sure of the right answer to know when the wrong answer is wrong.

Senator Murray: Of course, there are a great many members of the profession, and even members of the American Medical Association who disagree with you in these views. Dr. Goin: Well, a great many in that a few thousand are a great many. But I think 95% of the physicians of America would agree with my views.

[*Senator Murray then read a statement showing that a group of well known physicians, all members of the American Medical Association, in a telegram to Dr. Channing Frothingham, took sharp exception to the American Medical Association's stand on the Wagner-Murray-Dingell Bill.—Ed. Canad. M. A. J.*]

Senator Murray: So there are a great many doctors around the country that are giving study to this problem and are of the opinion that a compulsory health system would be advisable in this country. Dr. Goin: Senator, might I remark that it is not at all established that these men have given study to this problem? Perhaps they are well wishers who would like to see good done to humanity. It, I think, would be very interesting to know how many of the telegrams Dr. Frothingham sent out did not get affirmative answers. I spent Sunday with a man in New York who is a professor of pædiatrics at Columbia who refused to send such a telegram. His name is not there. I do not think it is a very large number compared to the number of doctors, and if it please the committee I could within ten days get a similar telegram signed by one thousand names for each name on there.

Senator Murray: I am not disputing that. I am merely pointing out that these men who are on that list are men of prominent standing and distinction in the country. Dr. Goin: That is true.

Senator Murray: And that they are giving study to the problem and are of the opinion that a compulsory health system is advisable. Dr. Goin: That is right. Some of them have devoted their lives to getting a compulsory health system activity. Peters, Addis and Butler, for instance, devoted almost their entire lives to getting such a system. I presume they are sincere.

Senator Murray: When did these doctors commence to promote such a program? Dr. Goin: I know Addis, to my personal knowledge, has been advocating it for sixteen years.

Senator Murray: And the American Medical Association generally opposes it? Dr. Goin: That is right.

Senator Murray: I notice that in this report of "Medical Care for the American People", which was issued in 1932, a committee on the costs of medical care, that the American Medical group at that time was opposed to the voluntary system. That is true, is it not? Dr. Goin: I could not say, but I would not be at all surprised, because as I said before at that time we had no body of facts on which to proceed on a voluntary health care plan, and they had to be worked out piecemeal, slowly, painfully and frequently expensively.

Senator Murray: I had reference here to the minority report at that time signed by— Dr. Goin: The signers of the minority report do not represent the American Medical Association. It represents eight doctors, members of this committee.

Senator Murray: The members who were on that committee at that time? Dr. Goin: Well, they were just doctors who were on the committee. I do not know if they are even members of the American Medical Association. They were certainly not there in that capacity.

Senator Murray: They consist of A. C. Christie, George E. Follansbee, M. L. Harris, Kirby S. Cowlett, Arthur C. Morton, N. B. Van Etten, Robert Wilson, Alphonse M. Schwitalla and Olin West. Dr. Goin: Schwitalla, for instance, is a Jesuit priest; not a doctor at all.

Senator Murray: He is a professor at St. Louis University. Dr. Goin: He is dean of the St. Louis Medical University and is a priest; not a physician.

Senator Murray: I understand that. He is a student of these problems. Dr. Goin: But not a member of the American Medical Association.

Senator Donnell: If I may interrupt, I call attention to page 151 of the volume from which the chairman is reading at which Dr. Schwitalla is described as "A. M. Schwitalla, Ph.D." I think the other gentlemen are mentioned as "M.D." but he is referred to as "Ph.D."

Senator Murray: After this meeting of the committee that was set up at that time, these medical men who signed this report opposed the voluntary system and advocated the compulsory system. Is that right? Dr. Goin: I could not answer. I do not know. I am not familiar with it.

Senator Murray: I will read it. Dr. Goin: I think it would be of little significance since it is nearly sixteen years since the report was written. A great many things have happened.

[*Later Dr. Goin showed that several of the medical men supporting compulsory health insurance were very largely whole time salaried men who did not actively practise medicine.—Ed. Canad. M. A. J.*]

COSTS OF COMPULSORY INSURANCE

Senator Donnell: Doctor, you were referring to the costs of this compulsory insurance, and I understood your statement to be that it was impossible to determine what it is. I want to call to your attention in that connection, however, one fact that appeared to me was somewhat significant, and that is that you point out that experience elsewhere indicates that there is needed, at least, one employee, not including those actually delivering medical service, for each hundred insured persons. Is that correct? Dr. Goin: That is taken from a citation.

Senator Donnell: From Crownhart on "Sickness in Europe". That is a publication of 1938. Dr. Goin: Yes.

Senator Donnell: You pointed out that on this basis it would need to increase the government payroll by about one and a half million employees. Dr. Goin: Yes.

Senator Donnell: My recollection, Mr. Chairman, is that our esteemed colleague Mr. Byrd has pointed out that there are 3,160,000 governmental employees at this time. So that your judgment is, I take it, from what you state here, that, assuming the facts set forth by Mr. Crownhart to be correct, the number of government employees would have to be increased by something over a third of what are now employed by the government. Dr. Goin: That would seem to be the case.

Senator Donnell: Those, I understand from your statement, do not include the doctors. Dr. Goin: That is right.

Senator Donnell: What would these one million and a half people be? Dr. Goin: They are the clerks and the administrative officers. It is just thousands of employees it takes to administer such a complex thing all over the United States.

Senator Donnell: You would have to have an employee in practically every city of any size in the United States, would you not? Dr. Goin: If I remember correctly, and I probably do not, in prewar Germany the sickness insurance, not including accident insurance, which was administered by a separate institute, had a national institute, thirteen regional institutes and something like thirty-three thousand local offices, each of which obviously has to have at least one employee. In Berlin the main institute is an enormous building comparable to our buildings here in Washington. It must be staffed with thousands of employees.

Senator Donnell: Roughly speaking, are you able to give us an estimate of what grade of salary this million and a half people, other than doctors, would receive? Is $2,000 a year too high for the average? Dr. Goin: I doubt if it is high enough.

Senator Donnell: Say we take $2,000 a year. That would be three billion dollars a year just for the employees, other than doctors. Dr. Goin: That is right.

Senator Donnell: Do you have any idea as to how many doctors would be engaged in this plan? Are you able to estimate at all? Dr. Goin: I hope a very small number, but I could not say.

Senator Donnell: But if the plan became effective, and reasonable opportunity was given for its success, undoubtedly there would be many thousands of doctors in it, would there not? Dr. Goin: I think it would take 150,000 doctors, or more, a good deal more, to administer it.

Senator Donnell: Do you think that it would take nearly all the time of nearly all of those men to administer their duties under this act? Dr. Goin: Goodness, I should think so.

Senator Donnell: What would you be able to estimate the average amount that those men would have to receive per person in order to compensate them adequately for their services? Dr. Goin: There is a deep secret. It was in California too when we had a long series of conferences with officers of the C.I.O., who insisted that they loved the medical profession and wanted to do well with them and thought they did not do well, ought to make more money and have more leisure for vacations, graduate study, research, if they guaranteed this bill. But when we came down to brass tacks, Mr. Minsky, their research expert, thought $5,000 would be ample for any doctor. Of course in England they only get about $2 per person per year, for insured persons.

Senator Donnell: Would your judgment be that $5,000 is certainly not too high? It would be, if anything, considerably too low to compensate for the average professionally equipped man who has put in his time studying for a profession of that type and importance. Dr. Goin: I would think so, although, of course, they get lower salaries than that in the Army and Navy and Public Health Service.

Senator Donnell: Would you think $5,000 a year, on the average, would be a fair estimate as to what they would have to have in order to live in reasonable respectability and commensurate with their position in life? Dr. Goin: I should guess so, because out of this $5,000 they have to maintain their office, assistance, telephone, automobile and supplies.

Senator Donnell: That would look low to me, but I take that figure as a very low figure. That figure would be $750,000,000 a year for the doctors. Now, I should not be a bit surprised if it would be a good bit more than that, would you? Dr. Goin: No.

Senator Donnell: If we take $750,000,000 a year and then take for the clerical employees and others that you have mentioned the one million and a half, three billion dollars, you get up to three billion, seven hundred and fifty million dollars as the cost of operation of this system. Now, with that in mind, Doctor— Dr. Goin: May I say that nearly all the experts think that much too low?

Senator Donnell: What do most of the experts think it would be? Dr. Goin: They think from four to four and a quarter billion dollars for the first year, and the actuarial opinion is that the cost will not begin to level for at least fifty years, and it is very likely to reach ten or twelve billion dollars.

MEDICAL SOCIETIES

Alberta: District Medical Meetings

Dr. Harold Orr, President Elect of the Canadian Medical Association, Alberta Division, has just completed a tour of the various medical districts in the Province. District meetings were held at Camrose, Medicine Hat, Lethbridge, Drumheller, Red Deer, and Dunvegan. Meetings of the Edmonton Rural District and Calgary Rural District were held in Edmonton and Calgary respectively. Attendance was excellent, reaching as high as 85% in Medicine Hat.

The Camrose Medical District meeting was held on May 23. Dr. Orr discussed the medical organization in Alberta, following which he outlined certain changes in regard to the treatment of Venereal Disease in the province. Dr. L. M. Rogers of Camrose, Council representative, discussed the College of Physicians and Surgeons matters, and Dr. D. R. Easton, Department of Veterans' Affairs, outlined the medical care of veterans, Dr. Bramley-Moore led a discussion on Health Insurance. Dr. Walter MacKenzie, Edmonton surgeon, gave a paper on "Ano-rectal lesions". Visitors at this meeting included Dr. Bane from the Department of Veterans' Affairs, Ottawa, and Dr. Douglas Thompson, Vice-president of the New Brunswick society.

Medicine Hat District Medical Society met on Monday, May 27. In the afternoon, papers were given by Dr. Walter MacKenzie, Edmonton, Dr. Max Cantor, Associate Professor of Biochemistry, University of Alberta, and Dr. H. Orr of Edmonton. In the evening, following the dinner, Divisional and College business was discussed. Dr. J. K. Mulloy, Department of Veterans' Affairs, Calgary, outlined the medical treatment of veterans, and Dr. W. Bramley-Moore, Registrar for the College, led the discussion of Health Insurance. A second paper was given by both Dr. MacKenzie and Dr. Cantor. This meeting was attended by a number of physicians from the province of Saskatchewan.

Lethbridge District Medical Society held a dinner meeting on Tuesday, May 28, and was attended by approximately 80% of the doctors in the district. Dr. Orr, as at previous meetings, outlined Divisional matters. Dr. S. M. Rose, Council representative, spoke on the affairs of the College, and Dr. J. K. Mulloy on medical care for veterans. Dr. W. Bramley-Moore spoke on Health Insurance and scientific papers were given by Dr. W. C. MacKenzie and Dr. Max Cantor. The Drumheller District Medical Society met at a dinner meeting on May 30, and the Red Deer District Medical Society met on May 31. At these meetings Dr. A. E. Archer, Lamont, outlined very comprehensively Health Insurance. Other business and scientific papers were as in Lethbridge.

On June 3, the President Elect's party attended a picnic meeting of the Peace River District Medical Society held at Dunvegan. In spite of rain this was attended by over 50% of the doctors in the district, some coming from a distance of more than 150 miles.

A new municipal hospital was opened recently at Oyen. This building will accommodate fifteen patients.

G. E. LEARMONTH.

Prince Edward Island Medical Society

On Tuesday evening, May 21, at the Charlottetown Hotel a dinner meeting, sponsored by the Educational Committee of the Prince Edward Island Medical Society, was largely attended by doctors from the various districts. Dr. E. M. Found presided. Dr. Skinner of Saint John, N.B. was the guest speaker and delivered an address on fractures and dislocations of the hip joint, illustrating his lecture with a choice selection of x-ray plates. Following a discussion period Dr. Skinner was tendered a vote of appreciation and thanks by the Society.

Saint John Medical Society

At the Annual Meeting of the Saint John Medical Society the following slate of officers for 1946-7 was elected: *President*—Dr. J. K. Sullivan; *Vice-president*—Dr. F. R. Connell; *Secretary*—Dr. Stephen Clark; *Treasurer*—Dr. Lachlan McPherson; *Executive Committee*—Drs. N. S. Skinner, Jos. Tanzman, J. P. McInerney; *Representative to N.B. Medical Executive*—Dr. Geo. S. Skinner.

La société médicale des hôpitaux universitaires de Québec

Séance à l'Hôpital du Saint-Sacrement vendredi le 15 février 1946.

MAIGREUR PAR ANOREXIE MENTALE.—Renaud Lemieux et Antonio Martel.

Les auteurs rapportent les observations de trois malades, deux jeunes filles et un jeune homme, dont l'âge moyen est de 25 ans, et qui présentent un syndrôme d'anorexie mentale. Ils signalent les symptômes caractéristiques qui permettent le diagnostic positif de l'anorexie mentale et sa différence de la maladie de Simmonds. Les auteurs font des considérations pathogéniques concernant ces deux affections: la maladie de Simmonds relevant d'une lésion hypophysaire primitive; l'anorexie mentale étant un syndrôme où dominent les troubles psychiques et dont tous les symptômes traduisent l'effet de l'inanition.

Le traitement de l'anorexie mentale doit avoir une double orientation: corriger d'abord le facteur psychoneurotique, puis forcer la ré-alimentation. L'emploi des extraits glandulaires doit se faire secondairement et avec prudence.

MÉNINGITE À BACILLE DE PFEIFFER.—Marcel Langlois, Roland Thibodeau et Marie Rousseau.

Après une revue de la littérature récente sur la thérapeutique des méningites à bacille de Pfeiffer, les